



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

JAMES BATES DDS MD
3001 KNOX STREET SUITE 301
DALLAS TX 78205

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name

TEXAS MUTUAL INSURANCE CO.

Carrier's Austin Representative Box

Box Number 54

MFDR Received Date

May 24, 2011

MFDR Tracking Number

M4-11-3242-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "On May 20, 2010, [injured worker] was injured on the job. Mr. Banfield was escorted to RHD Memorial Hospital by his supervisor. He went to the emergency room at 5:15PM that day. Dr. Bates is the Oral Surgeon that was on call at RHD Memorial that day. Dr. Bates went to the hospital and examined the patient and determined that the patient needed surgery. The patient was admitted to RHD Hospital and surgery was scheduled for the following morning. Dr. Bates performed the surgery on May 21, 2010. We want the carrier to remit payment to us for services rendered on the date of admission to the hospital, as well as the surgery performed the following date. It is believed that Texas Mutual incorrectly reduced the claim and services in question based on the Texas Workers Compensation Fee Schedule. Pursuant to Texas Administrative Code, Title 28, Part 2, Chapter 134, subchapter G, rule 134.600, (c), "The carrier is liable for all reasonable and necessary medical costs relating to health care: (1) listed in subsection (p) or (q) of this section only when the following situations occur: (A) an **emergency** as defined in Chapter 133 of this title (relating to General Medical Provisions);". Dr. Bates provided services to [injured worker] on an emergency basis. Please see the supporting documentation included in the dispute packet which include the initial patient intake forms from the Emergency room, and Dr. Bates' evaluation and operative report. Pursuant to Texas Administrative Code, Title 28, Part 2, Chapter 134, Subchapter G, rule 134.600(q), "the healthcare requiring concurrent review for an extension for previously approved services includes: (1) inpatient length of stay;" The patient was admitted to the hospital as an inpatient to wait for surgery until the patient was NPO. We feel the carrier should remit to us full payment of our fees based on our physician not participating in any workers compensation networks and yet providing emergency services for a worker injured on the job."

Amount in Dispute: \$8,191.05

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The following is the carrier's statement with respect to this dispute. This dispute concerns the proper amount of reimbursement for dental services provided over the disputed dates. 1. The requestor states in part, 'Our physician does not participate in any workers compensation networks in Texas. Therefore we require payment in full of our fees for the services that were rendered. Texas Workers compensation statute allows for full payment of non participating physicians rendering care on an emergency basis to a worker injured on the job.; Emergency treatment by a non-network provider on a Network claim does not default to payment of usual and customary fees in the presence of an existing state fee schedule. The requestor goes on to state that, 'We were advised on May 27, 2010 by the initial workers compensation adjuster, Tina Recer, that she approved paying us at our fee schedule for the emergency services. The file # 99L0000606994, her ph # 214.689.5405.' Texas Mutual has not delegated and does not delegate such authority

to the benefits administrators administering its workers' compensation claims. They have no such bde of authority. 2. The requestor did not use or bill DPT codes for the disputed dates. For this reason Texas Mutual paid the requestor from the Medical Fee Guideline... The requestor billed code 99254 for date 5/20/10. Because Medicare discontinued coverage of CPT code 99254 on 1/1/10 (MLM Matters® Number: MM6740 Revised) Texas Mutual denied payment. Texas Mutual will pay an additional \$0.08 per the variance from the Table."

Response Submitted by: Texas Mutual Insurance Co., 6210 E. Hwy 290, Austin, TX 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 20, 2010	CPT Code 99254	\$355.00	\$
May 21, 2010	CPT Code 21470	\$4,864.80	\$0.00
May 21, 2010	CPT Code 21453-59 $(38.19 \div 36.8729) \times \$812.27 = \$1,502.15 \div 2 = \$751.08 - \$664.73 =$	\$2,435.29	\$86.35
May 26, 2010	CPT Code 70140	\$97.40	\$0.00
May 26, 2010	CPT Code 70350	\$94.37	\$0.00
May 26, 2010	CPT Code 70355	\$92.73	\$0.00
June 9, 2010	CPT Code 70355	\$59.44	\$0.00
June 11, 2010	CPT Code 70355	\$92.73	\$0.00
July 26, 2010	CPT Code 99214-57	\$6.58	\$0.00
July 29, 2010	CPT Code 70355	\$92.71	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. [Add any rules that are pertinent to or cited in the body of your decision, with a brief description (you don't have to quote the text of the rule here, just describe what the rule is about).]
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated June 29, 2010 and August 10, 2010

- W1 – Workers Compensation state fee schedule adjustment.
- B18 – This procedure code and modifier were invalid on the date of service.
- 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- 435 – Per NCCI edits, the value of this procedure is included in the value of the comprehensive procedure.
- 790 – This chrg was reimbursed in accordance to the Texas Medical Fee Guideline.
- 893 – This code is invalid or not covered or has been deleted.

Explanation of benefits dated July 8, 2010

- 214 – Workers' Compensation claim adjudicated as non-compensable. This payer not liable for claim or service/treatment.
- 4 – The procedure code is inconsistent with the modifier used or a required modifier is missing.
- 420 – Supplemental Payment.
- 891 – No additional payment after reconsideration.

Explanation of benefits date September 10, 2010

- 18 – Duplicate claim/service.
- 59 – Process based on multiple or concurrent procedure rules.
- 224 – Duplicate charge.
- 329 – Allowance for this service represents 50% because of multiple or bilateral rules.

Issues

1. Under what authority is a request for medical fee dispute resolution considered?
2. Was this injury deemed compensable?
3. Did the requestor bill the respondent in accordance with the Texas Workers' Compensation Fee Guidelines?
4. Did the Respondent reimburse the requestor in accordance with the Texas Workers' Compensation Fee Guidelines?
5. Is the requestor entitled to reimbursement?

Findings

1. The requestor provided surgical services with dates of service May 20, 2010 through July 29, 2010 stating "We feel that the carrier should remit to us full payment of our fees based on our physician not participating in any workers compensation networks and yet providing emergency services for a worker injured on the job". The requestor was dissatisfied with the respondent's final action. The requestor filed for reconsideration and was denied payment after reconsideration. The requestor filed for dispute resolution under 28 Texas Administrative Code §133.307. The Division concludes that because the requestor sought the administrative remedy outlined in 28 Texas Administrative Code §133.307 for resolution of the matter of the request for additional payment, the dispute is to be decided under the jurisdiction of the Texas Workers' Compensation Act and applicable rules.
2. The respondent denied the treatment/procedures codes, with the exception of CPT Code 21470, using denial/reason code "214 – Workers Compensation claim adjudicated as non-compensable. This payer not liable for claim or service/treatment. Review of the Division files and notes did not find any PLN-11's filed for this date of injury. The disputed services will therefore be reviewed for payment in accordance with applicable Division rules and fee guidelines.
3. According to Texas Labor Code §413.013 The commissioner by rule shall establish: (2) a program for the systematic monitoring of the necessity of treatments administered and fees charged and paid for medical treatments or services, including the authorization of prospective, concurrent, or retrospective review under the medical policies of the division to ensure that the medical policies or guidelines are not exceeded; and (4) a program to increase the intensity of review for compliance with the medical policies or fee guidelines for any health care provider that has established a practice or pattern in charges and treatments inconsistent with the medical policies and fee guidelines. Review of the submitted documentation finds that the respondent reimburse the requestor in accordance with the Texas Workers' Compensation Fee Guidelines; and the requestor billed the services based on their physician not participating in any workers compensation networks; providing emergency services for a worker injured on the job.
4. According to the requestors' Table of Disputed Services the following CPT Codes were billed:
 - CPT Code 99254 is defined as an inpatient consultation for a new or established patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 80 minutes at the bedside and on the patient's hospital floor or unit. In accordance with 28 Texas Administrative Code §134.203 (b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules. According to MLM Matters® Number: MM6740, effective January 1, 2010, the Centers for Medicare & Medicaid Services eliminated the use of all consultation codes, (inpatient and office/outpatient codes), for various places of service. Therefore, reimbursement cannot be recommended.

- CPT Code 21470 is defined as open treatment of complicated mandibular fracture by multiple surgical approaches including internal fixation, interdental fixation, and/or wiring of dentures or splints. In accordance with 28 Texas Administrative Code §134.203(c) states that to determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is \$54.32. For Surgery when performed in a facility setting, the established conversion factor to be applied is \$68.19. The insurance carrier paid for professional services performed in an office setting, or services performed at a facility that per Medicare default to part B including Physical, Occupational, and Speech Therapy performed in a Hospital on an outpatient basis. The treatment provided to the injured worker qualified the requestor to bill and receive payment for professional services for surgeries performed at a facility because CPT Code 21740 is a surgical code and the services were provided in RHD Memorial Hospital in Dallas. The maximum allowable reimbursement for this code is \$2,178.27; the respondent made an initial payment of \$1,735.20 and a supplemental payment of \$443.07, for a total of \$2,178.27; therefore, the respondent has paid in accordance 28 Texas Administrative Code §134.203(b)(1) and additional reimbursement is not due.
 - CPT Code 21453-59 is defined as closed treatment of mandibular fracture with interdental fixation. In accordance with 28 Texas Administrative Code §134.203(b)(1) for coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules. This code is also subject to multiple procedure rules. One of the denial/reason codes used by the respondent to deny payment was "97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated." Review of the CCI edits for the code pair 21470 and 21453 indicates a modifier may be used so that the code pair may be billed together. Modifier-59 is described as distinct procedural service; furthermore, under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used. The requestor attached modifier -59 to this code. Review of the operative report supports the use of modifier -59 as a different procedure from code 21470. Therefore, reimbursement is due to the requestor.
 - The requestor also listed CPT Codes 70140, 07350, 70355 (4 different dates of service), and 99214-57 as being in dispute. In accordance with 28 Texas Administrative Code §133.307(c) Requests for MFDR shall be filed in the form and manner prescribed by the division. Requestors shall file two legible copies of the request with the division. (2) The requestor shall provide the following information and records with the request for MFDR in the form and manner prescribed by the division. The provider shall file the request with the MFDR Section by any mail service or personal delivery. The request shall include: (J) a paper copy of all medical bill(s) related to the dispute, as originally submitted to the insurance carrier in accordance with this chapter and a paper copy of all medical bill(s) submitted to the insurance carrier for an appeal in accordance with §133.250 of this chapter (relating to General Medical Provisions). Review of the documentation submitted reveals the medical bills for these services were not included; therefore, the Division cannot confirm the services were rendered as billed. Additional reimbursement cannot be recommended.
5. The requestor submitted documentation to support that additional reimbursement for Code 21453 is due.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$86.35.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$86.35 reimbursement for the disputed services.

Authorized Signature

_____	_____	June 28, 2010
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.